Name of Child:

_____

Nickname: _____ Birth Date: ___/___/_____

Age at entry: _____

Parent(s) or Guardian(s) **Contact Information:**

1. Name: _____ Relationship: _____
   Mailing Address: _____ Home Phone #: _____
   Street Address: _____ Cell Phone #: _____
   City / State / Zip: _____ Email Address: _____
   Employer: _____ Work Hours: _____
   Worksite Location: _____ Work Phone #: _____

2. Name: _____ Relationship: _____
   Mailing Address: _____ Home Phone #: _____
   Street Address: _____ Cell Phone #: _____
   City / State / Zip: _____ Email Address: _____
   Employer: _____ Work Hours: _____
   Worksite Location: _____ Work Phone #: _____

Other children in the household:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

My signature gives permission for the following:

In an emergency, I hereby authorize a representative of Temple Emek Shalom, 1800 E. Main Street, Ashland, Oregon 97520 [541] 488-2909, to call an ambulance or to take my child to any available physician or hospital, at my expense, and to obtain medical treatment for my child. In most emergencies, 911 will be called, and the child be transported to Ashland Community Hospital and seen by the emergency medical physician on call. (Parents are always notified as soon as possible.)

I authorize a representative of Temple Emek Shalom to give non-prescription medication as indicated on the container, including sunscreen, Benadryl and antibacterial first aid cream, unless otherwise indicated in the allergies section above. Syrup of ipecac may be administered if deemed necessary by the poison control operator.

- I give permission for my child's photograph, without the name, to be used on the

Pomegranate website (please initial): _____

Print Parent / Guardian Name:

_____

Signature:

_____

Date: ____/_____/_____

FOR OFFICE USE ONLY:

Deposit Received _____ Date Received ____
Materials Fee Received _____ Date Received _____
Vaccination Forms Received _____ Date Received _____